AIDS—A New Epidemic

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) is a disease characterized by the occurrence of unusual neoplasms, chiefly Kaposi's sarcoma, and opportunistic infections, usually *Pneumocystis carinii* pneumonia. It was first recognized in June 1981 in six previously healthy homosexual men, and by April 1984 some 3,954 cases had been reported to the Centers for Disease Control, affecting homosexual men, intravenous drug abusers and Haitians both in and outside Haiti. Other groups affected include persons with hemophilia and other transfusion recipients, female sexual partners of men with the disease and infants from high-risk households. The ultimate mortality is unknown, but may approach 100%.

AIDS is defined empirically as the occurrence of infections and malignant lesions characteristic of an immunologic deficiency in the absence of any other cause of immunodeficiency. Basic science and clinical study of the disease has been hampered by the lack of a specific diagnostic marker. The classic syndrome commonly begins with *P carinii* pneumonia manifested by cough, chest discomfort and mild fever for two to ten weeks, accompanied by weight loss and diarrhea with or without enteric pathogens. Oral *Candida,* primary or recurrent herpes simplex and disseminated cytomegalovirus and Epstein-Barr viruses are frequently seen. Other opportunistic infections may also be found.

Two types of malignancy are seen with AIDS: Kaposi's sarcoma occurs in about 35% of patients, is commonly disseminated and usually presents as blue or brown nodules or plaques, usually on the legs; Burkitt's or immunoblastic lymphomas occur less frequently.

In addition, there is a syndrome of chronic lymphadenopathy, defined as three months' duration involving two or more extrainguinal sites with reactive hyperplasia on the lymph node biopsy specimen in the absence of illness or drugs that might cause lymphadenopathy. It is not clear if this represents a prodrome of AIDS or an entirely different syndrome, but in many who have it, classic AIDS develops.

Lymphopenia may be present, and T-cell subset analysis shows a decreased helper-suppressor cell ratio. Additionally, there is polyclonal B-cell activation with increased levels of serum immunoglobulin and abnormalities in the serologic response to a new antigen.

The cause of AIDS is yet unknown, but epidemiologic data suggest a single agent transmitted in a manner like hepatitis B, with an incubation period of about 18 months. Recent virologic and immunologic studies have shown the presence of human T lymphotrophic retroviruses (HTLV III) in a large percentage of those who have AIDS. Further studies are needed before causality can be determined or an immunization developed.

AIDS is clearly spread by sexual contact and via bloodborne transmission. There is no evidence that it is transmitted through casual contact. It appears to be concentrated in the United States, largely in major cities on both coasts, but is also seen in Europe, Haiti and Africa. The number of new cases is doubling every six months, and though about 3% of cases belong to a no-known-risk group, it is unknown whether the epidemic will extend into the general population.

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Premenstrual Syndrome

PREMENSTRUAL SYNDROME has become a popular topic in the lay press over the past few years, and it also has a growing medical literature. Because it is common (20% of women of childbearing age) and because treatment relies heavily on a good doctor-patient relationship, this disorder is well suited for treatment by a family practitioner.

Premenstrual syndrome is defined as an array of somatic and psychologic symptoms that occur during the luteal phase of the menstrual cycle and disappear sometime during menses. The symptoms are variable in occurrence and severity, but are significant enough to cause temporary incapacitation.

Common somatic symptoms are bloating, breast pain or tenderness, edema, skin rashes, hot flushes, headache, pelvic pain and change in bowel habits. Common psychological symptoms are irritability, aggression, tension, anxiety, depression, lethargy, insomnia, change in appetite, crying, change in libido, thirst, loss of concentration and poor coordination.

Diagnosing the disorder is dependent on a careful history. A diary of somatic and psychological symptoms during the menstrual cycle is essential for careful diagnosis. Three common patterns of symptoms occur. Some patients have problems during the week before menstruation whereas others become symptomatic starting at ovulation and are affected for two weeks. Others experience a few days of symptoms at the time of ovulation, with recurrence during the week before the menses. The symptoms generally disappear by the second day of menses.

Patient education and reassurance are the most important aspects of therapy. Many women find relief with an understanding of the condition and with reassurance that they are not suffering from a mental illness. General measures that may be helpful are regular exercise and a low-salt, low-carbohydrate (especially simple sugars), high-protein diet. Discontinuation of nicotine and caffeine is also advisable.

Pyridoxine hydrochloride (vitamin B_6) in dosages of 200 mg to 800 mg daily is generally the first choice